



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DANIEL O. THOMPSON III, MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-0085-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

SEPTEMBER 9, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I first billed by regular mail on 04-20-2013 but received no response. I then re-billed on 06-27-2013, with confirmation of delivery, but again received no response."

Telephone Call on April 1, 2014 to Tatyana Thompson confirmed payment of \$500.00 of the \$800.00 was received, and requestor still wishes to pursue the remaining \$300.00.

Amount in Dispute: \$300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated September 26, 2013: "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the disputed services."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2013	CPT Code 99456-W5-WP Designated Doctor Evaluation for MMI/IR	\$300.00	\$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. Neither party to this dispute submitted copies of the explanation of benefits to support denial/reduction of payment for the disputed services.

Issues

Is the requestor entitled to additional reimbursement for CPT code 99456-W5-WP?

Findings

On the disputed date of service the requestor billed CPT code 99456-W5-WP.

- 28 Texas Administrative Code §134.204(i)(1)(A) states “The following shall apply to Designated Doctor Examinations. (1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: (A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier “W5” is the first modifier to be applied when performed by a designated doctor”

A review of the submitted medical billing finds that the requestor billed modifier “W5” as the first modifier appended to CPT code 99456.

- 28 Texas Administrative Code §134.204(j)(3) states “The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.”

The requestor billed CPT code 99456 because the examination was performed by a designated doctor.

- 28 Texas Administrative Code §134.204(j)(4)(C)(iii) states “If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier “WP.” Reimbursement shall be 100 percent of the total MAR.”
- 28 Texas Administrative Code §134.204(n)(18) states “The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. The “WP” modifier is defined as “Whole Procedure--This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single HCP.”

A review of the requestor’s billing finds that the “WP” modifier was appended to CPT code 99456 to designate that the provider had performed the MMI examination and the IR testing.

The maximum allowable reimbursement (MAR) for CPT code 99456-W5-WP is:

- 28 Texas Administrative Code §134.204(j)(1) states “Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:
 - (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR.
- 28 Texas Administrative Code §134.204(j)(4)(C) states “For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.”
- 28 Texas Administrative Code §134.204(j)(4)(C)(ii) states “The MAR for musculoskeletal body areas shall be as follows.
 - (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
 - (II) If full physical evaluation, with range of motion, is performed:
 - (-a-) \$300 for the first musculoskeletal body area; and
 - (-b-) \$150 for each additional musculoskeletal body area.”

Per the submitted medical bill, the requestor billed for MMI/IR of three body areas. A review of the Designated Doctor report finds that a DRE examination was performed on the left wrist, hip, low back and knee; therefore, the documentation supports billing of three areas. The MAR is \$150.00 per body area 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I). The total allowable for the impairment rating is \$450.00.

Per 28 Texas Administrative Code §134.204(j)(3)(C) the requestor is due \$350.00 for the MMI evaluation.

The Division finds that the total allowable for the MMI/IR evaluation is \$800.00. The respondent paid \$500.00. As a result, the requestor is entitled to reimbursement of \$300.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	11/05/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.